SUFFOLK COUNTY HEAP
COOLING COMPONENT

Date:

DOCTORS INFORMATION

Name: _____

Address: _____

Phone#: _____ **Fax#:** _____

REGARDING (Patients Information)

Name: _____

Address: _____ Phone#: _____

Dear HEAP Representative:

I am writing on behalf of _____ to document the medical necessity of an air
(patient name)
conditioner or fan due to the following medical condition/conditions _____

_____ that is/are exacerbated by heat.

Please contact me if any additional information is required to ensure the prompt approval of this benefit.

Please fax letter to 631-853-8822 or scan to HEAPCentral@suffolkcountyny.gov.

Sincerely,

_____
(Doctor's signature)

Suffolk County Department of Social Services
P.O. Box 18100 • Hauppauge, NY 11788